Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
SEPTEMBER 17, 2004

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-05-0560-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this instance, the patient was admitted for three days for surgical inpatient services. Therefore, in accordance with the formula, the WCRA is 1 X $1118.00 = $1118.00. The prior amount paid by the carrier was $0. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of ($1180.00) = **$1180.00, plus interest**."

Amount in Dispute: $1,118.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that the bill for DOS of 10/16/03 was never received. The bill was sent to the wrong address. Carrier has requested the bill from the Provider but as of yet has not received it. Carrier will process the bill in accordance with MFG upon submission of proper documentation by the Requestor. Carrier is completing the TWCC-60 and returning it with this response."

Response Submitted by: Zurich c/o FOL, 505 West 12th St., Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2003 through October 17, 2003	Inpatient Services	$1, 118.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264, sets out the reimbursement guidelines for inpatient hospital services.

3. 28 Texas Administrative Code §133.304, effective July 15, 2000, 25 *Texas Register* 2115, sets out the procedure for submitting and auditing medical bills.
4. 28 Texas Administrative Code §133.300, effective July 15, 2000, 25 *Texas Register* 2115, sets out the procedure for insurance carrier's receipt of medical bills from health care providers.

Findings

1. 28 Texas Administrative Code §133.300(b) states "The insurance carrier shall date stamp each medical bill and each individual document attached to the bill to indicate the date of receipt. Failure to date stamp the bill and/or attachments creates a rebuttable presumption that the insurance carrier received the bill and attachments five days after the bill was sent to the insurance carrier. For electronically submitted bills, the insurance carrier shall be able to produce documentation indicating the date the insurance carrier received the electronically submitted bill."

   The respondent states in the position summary that "Carrier maintains that the bill for DOS of 10/16/03 was never received. The bill was sent to the wrong address."

   The requestor submitted a signed certified green card and mail receipt that listed an address in Schaumburg, IL. In addition, the requestor submitted a copy of a facsimile confirmation report dated April 7, 2004. The 14 pages were sent to fax number (979)848-1070. A review of the hospital bill and submitted DWC-60 list a different address and facsimile number.

   The requestor has supported their position that the medical bills were sent; however, the documentation does not support that this was the respondent's address and facsimile number.

2. 28 Texas Administrative Code §133.304(k) states "If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit the request for reconsideration by facsimile or mutually agreed upon electronic transmission unless the request cannot be sent by those media, in which case the sender shall send the request by mail or personal delivery."

   The submitted documentation does not support that the respondent received the original bill or the reconsideration bill for dates of service October 16, 2003 through October 17, 2003.

3. 28 Texas Administrative Code §133.304(m) states "The sender of a medical bill may request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution) if the sender of a medical bill has requested reconsideration in accordance with this section."

   The submitted documentation does not support that the disputed medical bill has been submitted for reconsideration to the respondent.

4. 28 Texas Administrative Code §133.307(g)(3)(A) states "documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request."

   The requestor did not submit convincing evidence that the insurance carrier received the disputed medical bills.

5. 28 Texas Administrative Code §133.307(m)(3), states "The commission may dismiss a request for medical fee dispute resolution if: (3) the commission determines that the medical bills in the dispute have not been properly submitted to the carrier for reconsideration pursuant to §133.304."

   The Division finds insufficient documentation to support that the medical bills in the dispute have not been properly submitted to the carrier for reconsideration pursuant to §133.304. As a result, reimbursement cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		05/10/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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